		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038687

Facility Name: Blu-Fountain Manor

Address: 1623-29 W. Delmar (Number) Godfrey (City) 62035 (Zip Code)

County: Madison

Telephone Number: (618) 466-0443 **Fax #** (618) 466-9151

IDPA ID Number: 95-3750883002

Date of Initial License for Current Owners: 12/31/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Greg LeRoy **Telephone Number:** (479) 201-4371

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 03/30/04 (Date)
(Type or Print Name) Greg Swartz
(Title) Assistant Secretary

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	68	Skilled (SNF)	68	24,820	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	166	3,771	2,506	6,443	8
9	SNF/PED					9
10	ICF	15,088			15,088	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,254	3,771	2,506	21,531	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.75%

D. How many bed-hold days during this year were paid by Public Aid?
31 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 2,525

Medicare Intermediary United Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: #######

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	93,940	5,376	2,357	101,673		101,673	857	102,530			1
2	Food Purchase		82,491		82,491		82,491	(3,298)	79,193			2
3	Housekeeping		380	64,223	64,603		64,603	510	65,113			3
4	Laundry		2,577	42,815	45,392		45,392		45,392			4
5	Heat and Other Utilities			57,041	57,041	977	58,018	1,273	59,291			5
6	Maintenance	19,280	8,666	37,846	65,791		65,791	(1,422)	64,369			6
7	Other (specify):*			571	571		571		571			7
8	**TOTAL General Services**	113,220	99,490	204,852	417,562	977	418,539	(2,080)	416,459			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	805,619	34,508	29,838	869,965	4	869,969	(13,173)	856,796			10
10a	Therapy			214,042	214,042		214,042	(65,020)	149,022			10a
11	Activities	31,956	2,322	5,736	40,014		40,014	(2)	40,012			11
12	Social Services	39,496		1	39,497		39,497		39,497			12
13	Nurse Aide Training			4	4	(4)	0		0			13
14	Program Transportation			3,048	3,048		3,048	(50)	2,998			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	877,071	36,830	265,869	1,179,770		1,179,770	(78,245)	1,101,525			16
	C. General Administration											
17	Administrative			144,935	144,935	67,145	212,080	27,425	239,505			17
18	Directors Fees											18
19	Professional Services			730	730		730		730			19
20	Dues, Fees, Subscriptions & Promotions			17,096	17,096		17,096	(7,198)	9,898			20
21	Clerical & General Office Expenses	111,280	11,465	38,231	160,976	(67,145)	93,831	(22,781)	71,050			21
22	Employee Benefits & Payroll Taxes			217,101	217,101		217,101	12,045	229,146			22
23	Inservice Training & Education			930	930		930		930			23
24	Travel and Seminar			959	959		959	(86)	873			24
25	Other Admin. Staff Transportation			546	546		546		546			25
26	Insurance-Prop.Liab.Malpractice			64,318	64,318		64,318	39,913	104,231			26
27	Other (specify):*	448		1,313	1,761		1,761	(1,761)	0			27
28	**TOTAL General Administration**	111,728	11,465	486,160	609,353		609,353	47,557	656,910			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,102,019	147,785	956,882	2,206,685	977	2,207,662	(32,768)	2,174,894			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Blu-Fountain Manor 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			50,198	50,198		50,198	5,324	55,522			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(9)	(9)		(9)		(9)			32
33	Real Estate Taxes			17,837	17,837		17,837	5,981	23,818			33
34	Rent-Facility & Grounds			219,109	219,109		219,109		219,109			34
35	Rent-Equipment & Vehicles			33,420	33,420	(977)	32,443	474	32,917			35
36	Other (specify):*											36
37	**TOTAL Ownership**			320,556	320,556	(977)	319,579	11,779	331,358			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,267	296	73,563		73,563	(73,563)	0			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							40,392	40,392			42
43	Other (specify):*		6,348	7,113	13,462		13,462	(13,462)	(0)			43
44	**TOTAL Special Cost Centers**		79,616	7,409	87,025		87,025	(46,633)	40,392			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,102,019	227,401	1,284,847	2,614,266		2,614,266	(67,622)	2,546,644			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,065)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(71)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		27		18
19	Entertainment				19
20	Contributions	(326)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,700)	21		24
25	Fund Raising, Advertising and Promotional	(5,538)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,206)	20		28
29	Other-Attach Schedule	(2,334)	5A		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,240)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(34,243)	17	34
35	Other- Attach Schedule	(6,139)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (40,382)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,622)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Blu-Fountain Manor

ID# 0038687

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	UR Fees	$ 0		1
2	Barber & Beauty			2
3	Patient Loss	(120)	27	3
4	Vendor Service Charge	(1,150)	27	4
5	Bank Service Charge	(55)	21	5
6	Magical Moments	0	20	6
7	Additional Facility Rent	0	34	7
8	Corporate Collection Fees	(341)	21	8
9	Patient Personal Supplies	(668)	10,27	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,334)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	857	0	0	0	0	0	0	0	0	0	0	857	1
2	Food Purchase	(3,298)	0	0	0	0	0	0	0	0	0	0	(3,298)	2
3	Housekeeping	510	0	0	0	0	0	0	0	0	0	0	510	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	1,273	0	0	0	0	0	0	0	0	0	0	1,273	5
6	Maintenance	(1,422)	0	0	0	0	0	0	0	0	0	0	(1,422)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,080)	0	0	0	0	0	0	0	0	0	0	(2,080)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(13,173)	0	0	0	0	0	0	0	0	0	0	(13,173)	10
10a	Therapy	(65,020)	0	0	0	0	0	0	0	0	0	0	(65,020)	10a
11	Activities	(2)	0	0	0	0	0	0	0	0	0	0	(2)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(50)	0	0	0	0	0	0	0	0	0	0	(50)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(78,245)	0	0	0	0	0	0	0	0	0	0	(78,245)	16
	C. General Administration													
17	Administrative	27,425	0	0	0	0	0	0	0	0	0	0	27,425	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,198)	0	0	0	0	0	0	0	0	0	0	(7,198)	20
21	Clerical & General Office Expenses	(22,781)	0	0	0	0	0	0	0	0	0	0	(22,781)	21
22	Employee Benefits & Payroll Taxes	12,045	0	0	0	0	0	0	0	0	0	0	12,045	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(86)	0	0	0	0	0	0	0	0	0	0	(86)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	39,913	0	0	0	0	0	0	0	0	0	0	39,913	26
27	Other (specify):*	(1,761)	0	0	0	0	0	0	0	0	0	0	(1,761)	27
28	**TOTAL General Administration**	47,557	0	0	0	0	0	0	0	0	0	0	47,557	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,768)	0	0	0	0	0	0	0	0	0	0	(32,768)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Blu-Fountain Manor** **#** **0038687** **Report Period Beginning:** **1/1/2003** **Ending:** **12/31/2003**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,324	0	0	0	0	0	0	0	0	0	0	5,324	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	5,981	0	0	0	0	0	0	0	0	0	0	5,981	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	474	0	0	0	0	0	0	0	0	0	0	474	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	11,779	0	0	0	0	0	0	0	0	0	0	11,779	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(73,563)	0	0	0	0	0	0	0	0	0	0	(73,563)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	40,392	0	0	0	0	0	0	0	0	0	0	40,392	42
43	Other (specify):*	(13,462)	0	0	0	0	0	0	0	0	0	0	(13,462)	43
44	**TOTAL Special Cost Centers**	(46,633)	0	0	0	0	0	0	0	0	0	0	(46,633)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,622)	0	0	0	0	0	0	0	0	0	0	(67,622)	45

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Beverly Health & Rehabilitation Services	100	More than 370 facilities throughout the U.S.		Aegis Therapies, Inc.	Fort Smith, AR	Therapy
				Ceres Stategies, Inc.	Fort Smith, AR	Purchasing
				AEDON Staffing, Inc.	Fort Smith, AR	Nursing Staffing
				CSMS, Inc.	Fort Smith, AR	Purchasing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Home Office Costs	$ 143,704	Beverly Health & Rehabilitation Services	100.00%	$ 166,802	$ 23,098	1
2	V	10	Nursing Consultant	17,351	Beverly Health & Rehabilitation Services	100.00%	21,059	3,708	2
3	V	01	Dietary Consultant	0	Beverly Health & Rehabilitation Services	100.00%	972	972	3
4	V	12	Housekeeping Consultant	0	Beverly Health & Rehabilitation Services	100.00%	510	510	4
5	V								5
6	V	10a	Therapy Expense/Home Office	214,043	Aegis Therapies, Inc.	100.00%	149,023	(65,020)	6
7	V	27	Home Office Costs	0	Ceres Strategies, Inc.	100.00%	2,489	2,489	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 375,098			$ 340,855	$ * (34,243)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Beverly Health & Rehabilitation Services
Street Address: One Thousand Beverly Way
City / State / Zip Code: Fort Smith, AR 72919
Phone Number: (479) 201-2000
Fax Number: (479) 201-4302

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Corp Home Office/QA Cost	Resident Days	86,645	3	$ 670,276	$ 310,261	21,562	$ 166,801	1
2										2
3	10	Corp Home Office Cost-Nursing	Resident Days	86,645	3	0	0	21,562	0	3
4	10	Corp QA Cost - Nursing	Resident Days	86,645	3	84,626	70,554	21,562	21,060	4
5										5
6	01	Corp QA Cost - Dietary	Resident Days	86,645	3	3,907	2,941	21,562	972	6
7										7
8	12	Corp QA Cost - Social Services	Resident Days	86,645	3	2,050	1,391	21,562	510	8
9										9
10	10a	Therapy/Home Office	Facility Specific		2	310,344	0	0	149,024	10
11										11
12	17,10,02	Corp Home Office	Facility Specific		3	9,094	0	0	2,489	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24		Rounding							(1)	24
25	TOTALS					$ 1,080,297	$ 385,147		$ 340,855	25

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3	CCA Financial, Inc.		X	Equipment Acquisition							42	3
4	(Turbolan)											4
5												5
	Working Capital											
6												6
7	Interest Income		X								(51)	7
8												8
9	TOTAL Facility Related						$	$			$ (9)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (9)	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 14,025 Line # 34

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	13,719	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	23,818	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,099	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	13,719	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	23,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	21,906	8
	1999	22,315	9
	2000	22,756	10
	2001	23,299	11
	2002	23,818	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Blu-Fountain Manor COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0038687

CONTACT PERSON REGARDING THIS REPORT Greg LeRoy

TELEPHONE (479) 201-4371 FAX #: (479) 201-4302

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-2-01-33-02-204-038	Encore-Blu Fountain Manor LLC	$ 23,818.00	$ 23,818.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,818.00	$ 23,818.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,144 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1985	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1985		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	LEASEHOLD IMPROVEMENTS			1993	41,060	2,201	5-20	2,201		31,102	10
11	(See depreciation schedule for asset detail of items acquired 1993 - 1999)			1994	3,300	259	5-20	259		2,473	11
12				1995	13,380	853	5-20	853		8,167	12
13				1996	12,789	636	5-20	636		8,183	13
14				1997	171,255	16,225	5-20	16,225		110,912	14
15				1998	26,576	2,096	5-20	2,096		12,658	15
16				1999			5-20				16
17	REPL:COMPRESSOR/A-C UNIT			2000	1,225	123	10	123		439	17
18	REPL COND 4 TON AC			2000	1,366	273	5	273		865	18
19				2000							19
20				2000							20
21				2000							21
22				2000							22
23				2000							23
24											24
25	REPL:WATER SOFTNER			2001	1,830	183	10	183		534	25
26	REPL:MIXING VALVE			2001	593	59	10	59		163	26
27	DISPOSAL			2001	637	127	5	127		319	27
28	WOOD FENCE			2001	1,900	238	8	238		495	28
29				2001							29
30				2001							30
31				2001							31
32				2001							32
33				2001							33
34				2001							34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIXED EQUIPMENT-15 YEAR LIFE	2002	$ 22,410	$ 1,494	15	$ 1,494	$	$ 2,615	37
38	CONSTRUCTION INTEREST	2002	322	22	15	22		38	38
39	DISHWASHER	2002	7,229	723	10	723		1,084	39
40	INSTALLATION/DISHWASHER	2002	649	65	10	65		86	40
41	REPL MIXING VALVE	2002	970	49	20	49		53	41
42		2002							42
43		2002							43
44		2002							44
45		2002							45
46		2002							46
47									47
48	CONTRACTOR PAY REQUESTS	2003	127,151	7,770	15	7,770		7,770	48
49	3 FIRE DOORS	2003	2,438	163	10	163		163	49
50	FIRE ALARM SYS/INSTALLATIO	2003	6,337	422	10	422		422	50
51	TAMPER ALARM/ELEC/FIRE SPR	2003	1,802	180	5	180		180	51
52	ROLLING FIRE DOOR/INSTAL	2003	3,501	117	10	117		117	52
53	ELEC WIRING/FIRE SHUTTER	2003	1,733	14	10	14		14	53
54		2003							54
55		2003							55
56		2003							56
57		2003							57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 450,453	$ 34,292		$ 34,292	$	$ 188,852	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 146,235	$ 19,397	$ 19,397	$	5-10	$ 83,158	71
72	Current Year Purchases	6,088	1,833	1,833		5-10	1,833	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 152,324	$ 21,231	$ 21,231	$		$ 84,992	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 602,777	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,522	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,522	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 273,843	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Encore Retirement Centers, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		68	12/31/85	$ 219,109	5	30	3
4	Additions							4
5								5
6								6
7	TOTAL		68		$ 219,109 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: Purchase of all Encore facilities *

10. Effective dates of current rental agreement:
Beginning 12/31/01
Ending 12/31/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/04	$ 219,160
13.	12/31/05	$ 219,160
14.	12/31/06	$ 219,160

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Chevrolet E-350	$ 721	$ 8,657	17
18					18
19					19
20					20
21	TOTAL		$ 721	$ 8,657	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Blu-Fountain Manor # 0038687 **Report Period Beginning:** 1/1/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,800	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,010)	395,794		3
4	Supply Inventory (priced at Historical Cost)	18,872		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	18,426		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 435,892	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	130,964		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	450,453		15
16	Equipment, at Historical Cost	152,324		16
17	Accumulated Depreciation (book methods)	(273,843)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 459,898	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 895,789	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 14,143	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,579		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,304		31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,524		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Contingencies			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 89,551	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	(210,391)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (210,391)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (120,840)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,016,629	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 895,789	$	48

***(See instructions.)**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,085,522	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,085,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(68,893)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Cost Report Equity Adjustments**	(0)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (68,893)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,016,629	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,482,626	1
2	Discounts and Allowances for all Levels	(324,583)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,158,043	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	290,298	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 290,298	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,598	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,478	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,186	19
20	Radiology and X-Ray	3,951	20
21	Other Medical Services	29,253	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 96,465	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Vending, Pat Pers Needs, Other Misc. Rev	567	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 567	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,545,373	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	417,562	31
32	Health Care	1,179,770	32
33	General Administration	609,353	33
	B. Capital Expense		
34	Ownership	320,556	34
	C. Ancillary Expense		
35	Special Cost Centers	46,633	35
36	Provider Participation Fee	40,392	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,614,266	40
41	**Income before Income Taxes (line 30 minus line 40)****	(68,893)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (68,893)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,120	2,120	$ 57,589	$ 27.16	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	10,831	11,850	216,804	18.30	3
4	Licensed Practical Nurses	8,915	9,750	140,865	14.45	4
5	Nurse Aides & Orderlies	39,917	41,992	374,007	8.91	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	2,036	2,092	22,044	10.54	9
10	Activity Assistants	1,439	1,444	10,129	7.01	10
11	Social Service Workers	3,217	3,512	39,630	11.28	11
12	Dietician	0	228	4,888	21.40	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	11,262	12,430	90,508	7.28	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,999	2,112	19,761	9.36	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	2,112	2,112	67,145	31.79	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	1,929	2,206	18,471	8.37	22
23	Office Manager	1,956	2,100	26,411	12.58	23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,541	1,630	13,767	8.44	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify) DSD Cooridnator	0	0	0		33
34	TOTAL (lines 1 - 33)	89,275	95,579	$ 1,102,019 *	$ 11.53	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 1,460	1-3	35
36	Medical Director		13,200	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		21,590	10-3	38
39	Pharmacist Consultant		2,754	10-3	39
40	Physical Therapy Consultant		0	N/A	40
41	Occupational Therapy Consultant		0	N/A	41
42	Respiratory Therapy Consultant		0	N/A	42
43	Speech Therapy Consultant		0	N/A	43
44	Activity Consultant		5,736	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify) Hskpg/Laundry		116,200	3,4	46
47	Maintenance		17,798	6	47
48	Profess,MedWaste, Transport		444	6,19	48
49	TOTAL (lines 35 - 48)		$ 179,182		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Donald Dill	Executive Director	0	$ 67,145
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,145

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Corporation Service Co. Inc.	Legal	$ 0
HR Solutions	Human Resource	286
Deloitte & Touche, LLP.	Accounting	444
	Adjustments	0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 730

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,018
Unemployment Compensation Insurance	0
FICA Taxes	0
Employee Health Insurance	49,345
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Injury	0
Payroll Taxes	94,178
Retirement Expense	(168)
Employee Fringe Benefits	3,704
Workers' Compensation Insurance Adjustment	9,742
Medical/Dental Ins Adjustment	(3,672)
Rounding	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 229,146

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 103
Advertising: Employee Recruitment	6,289
Health Care Worker Background Check	1,080
(Indicate # of checks performed 0)	
Dues and Subscriptions	4,456
Advertising and Public Relations	4,518
Community Education	1,730
Reclass Miscoded Expense	0
Less: PAC Fees/Contributions	(326)
Less: Public Relations Expense	( )
Non-allowable advertising	(6,746)
Yellow page advertising	(1,206)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,898

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	731
Meals	142
Personal ED Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 873

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Blu-Fountain Manor # 0038687 **Report Period Beginning:** 1/1/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association** **$3,242**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **Various**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,468** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **40,392**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,065**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **50%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Beverly is a publicly traded company audited as a wh**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.